

Estimate of the Situation

Critical Information for Critical Times, Edition of Wednesday, October 23, 2014



Subsidizing Failure

The U.S. Third Party Payer-based “health care” system is dying. That isn’t an opinion. It’s a mathematical certainty.

Public attention has been focused on costs to the Third Party Payer System. Costs to hospitals and physicians (lumped together by Third Party Payer System architects as “providers”) have been largely under the radar. That’s a problem. *Hospitals are effectively subsidizing Third Party Payer System operations at the expense of their own bottom lines.*

From 2010 through 2013, net patient revenue for 3,965 short-stay acute care and critical access U.S. hospitals totaled \$12,025,611,223. Operating expense for those hospitals was \$12,215,619,071. In aggregate, those hospitals experienced operating losses totaling \$190,007,848.

Although some individual hospitals are operating in the black, the aggregate cost of providing hospital care exceeds net patient revenue across the field. Moreover, operating revenue trend projections are uniformly dismal for hospitals of all sizes and types. See the charts in the next few pages for detail.

Nor are hospitals the only casualty. In its death spiral, the System is taking with it:

- The private practice of medicine.
- Local access to primary care.
- The viability of many rural communities for which small hospitals are the primary economic driver.
- The solvency of many of the nation’s largest states.
- Potentially the entire national economy.

Hospital insurance is not a synonym for health care to a real patient. The problem is not the cost of “health care”; the problem is the unsustainable cost of the Third Party Payer System. In addition to being a primary cause of rapidly rising hospital costs, the System’s requirements are a public relations disaster for hospitals and physicians. That at least 40% of a hospital’s generated charges will either not be paid at all or worse, that the costs underlying those charges will be shifted to patients who had nothing to do with their generation, is indefensible. When consumers of any highly desirable service are shielded from the cost of its consumption, demand for that service will be virtually infinite. The system to successfully emerge from today’s chaos will be built around that understanding. The time has come to build it.



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About the Graphs

Cost report data were used to identify revenue, expense, and operating income trends for U.S. acute care short-stay and critical access hospitals since 2010. We began by reviewing data for the 5,041 short-stay acute care and critical access U.S. hospitals and selected for inclusion the 3,965 hospitals for which complete data were available for the years 2010, 2011, 2012 and 2013. In the years 2010 through 2013, net patient revenue for those hospitals totaled \$12,025,611,223. Unfortunately, operating expense for those hospitals totaled \$12,215,619,071. In aggregate, the 3,965 hospitals experienced operating losses totaling \$190,007,848.

By size and type, the hospitals were distributed as follows:

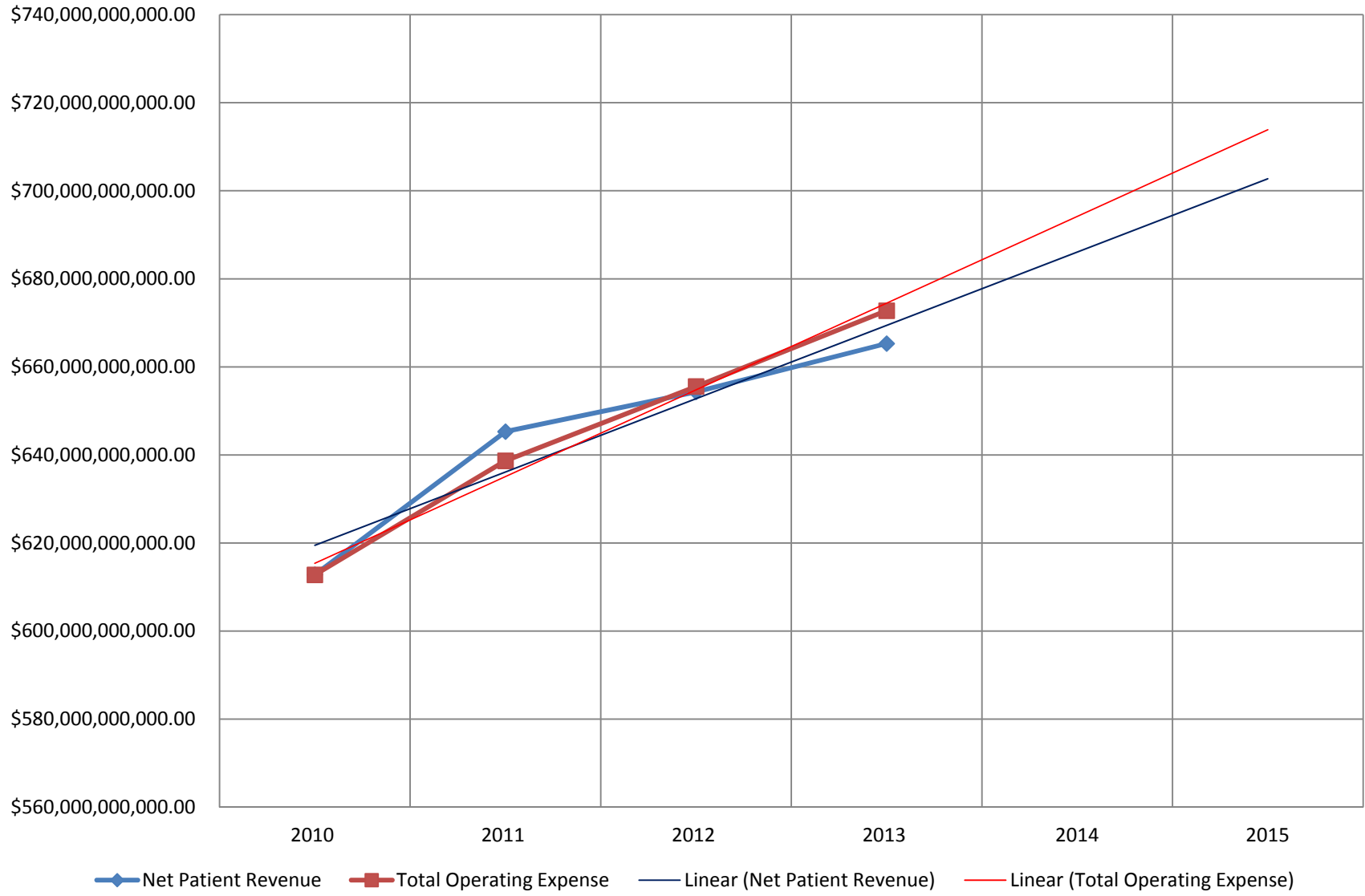
Hospital Type and Size	Number of Hospitals
Acute Care Hospitals- 0 to 25 ADC	749
Acute Care Hospitals- 25 to 75 ADC	757
Acute Care Hospitals- 75 to 150 ADC	616
Acute Care Hospitals- 150 to 300 ADC	564
Acute Care Hospitals- 300 to 500 ADC	184
Acute Care Hospitals- 500 ADC and Greater	75
Critical Access Hospitals- 0 to 8 ADC	587
Critical Access Hospitals- 8 to 15 ADC	353
Critical Access Hospitals- 15 to 25 ADC	<u>80</u>
Total:	3,965

Each group (by size and type) has two graphs.

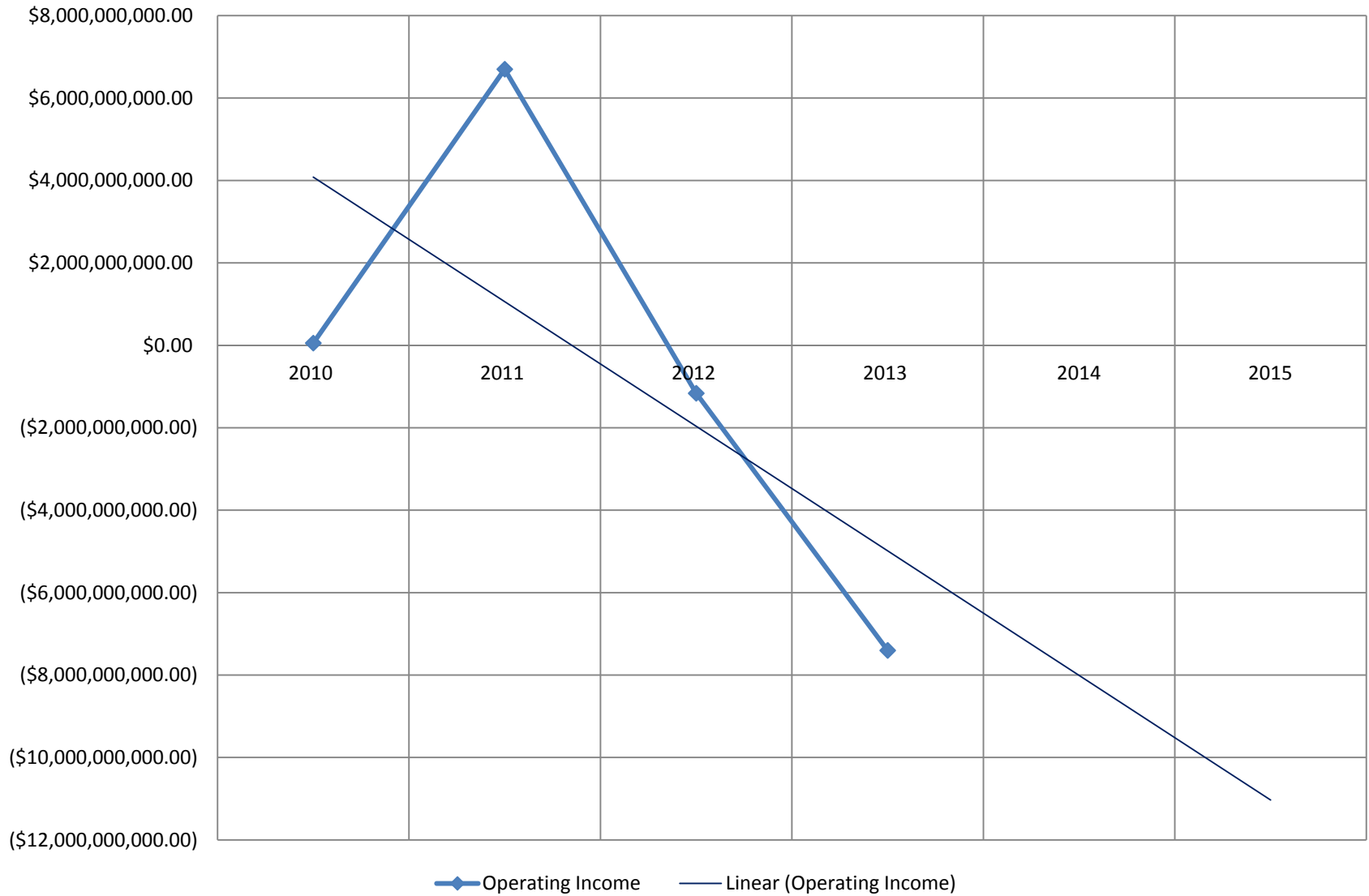
- The first graph will display year-to-year aggregate patient revenue and operating expense and projected trends.
- The second graph will display year-to-year aggregate operating income and projected trends.

Either linear or polynomial regression was used in trend projection depending upon observed data point distribution.

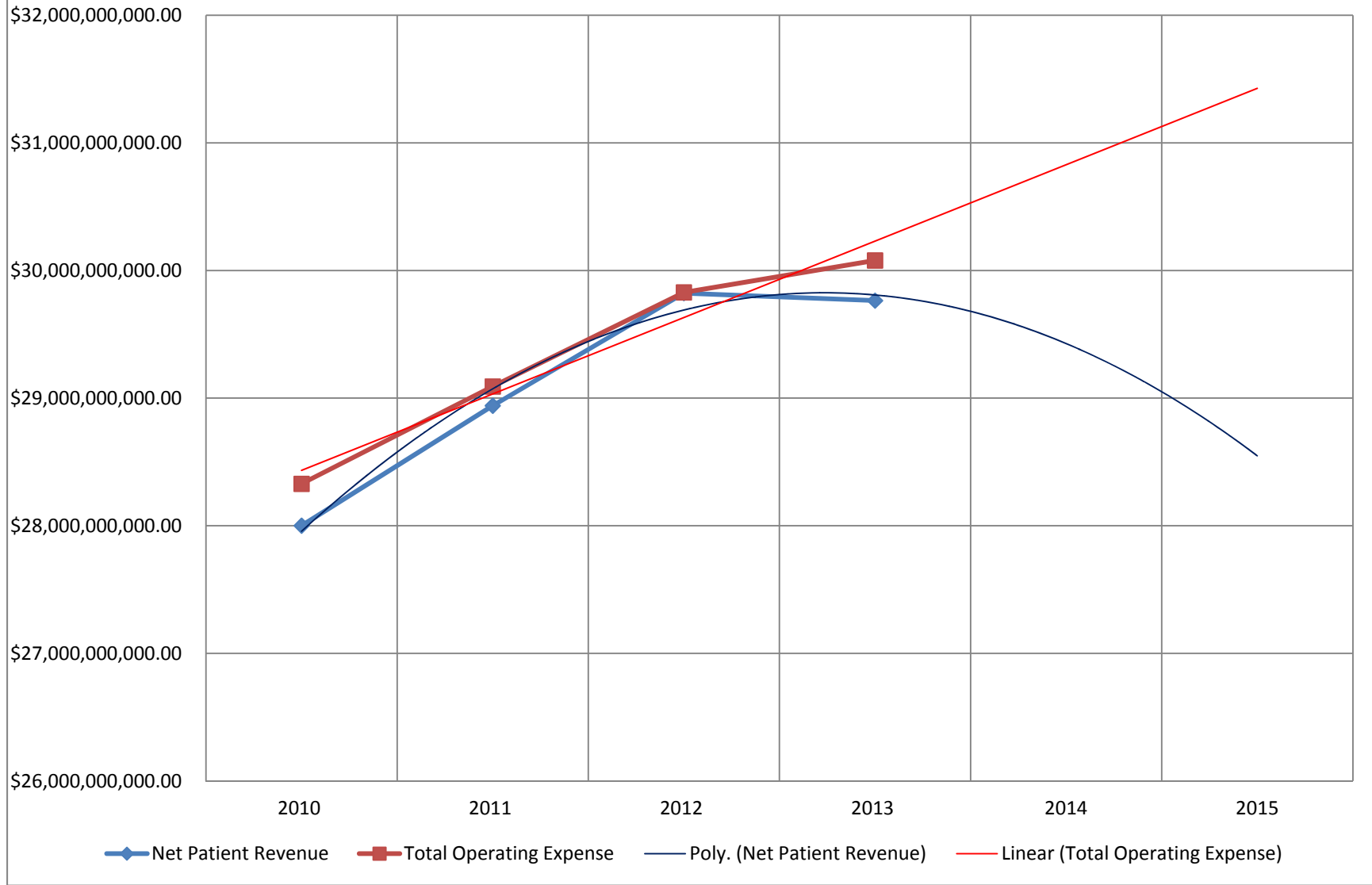
3,965 Acute Care and Critical Access Hospitals (ADC 1.02 to 1,749.55) Revenue and Expense Trends

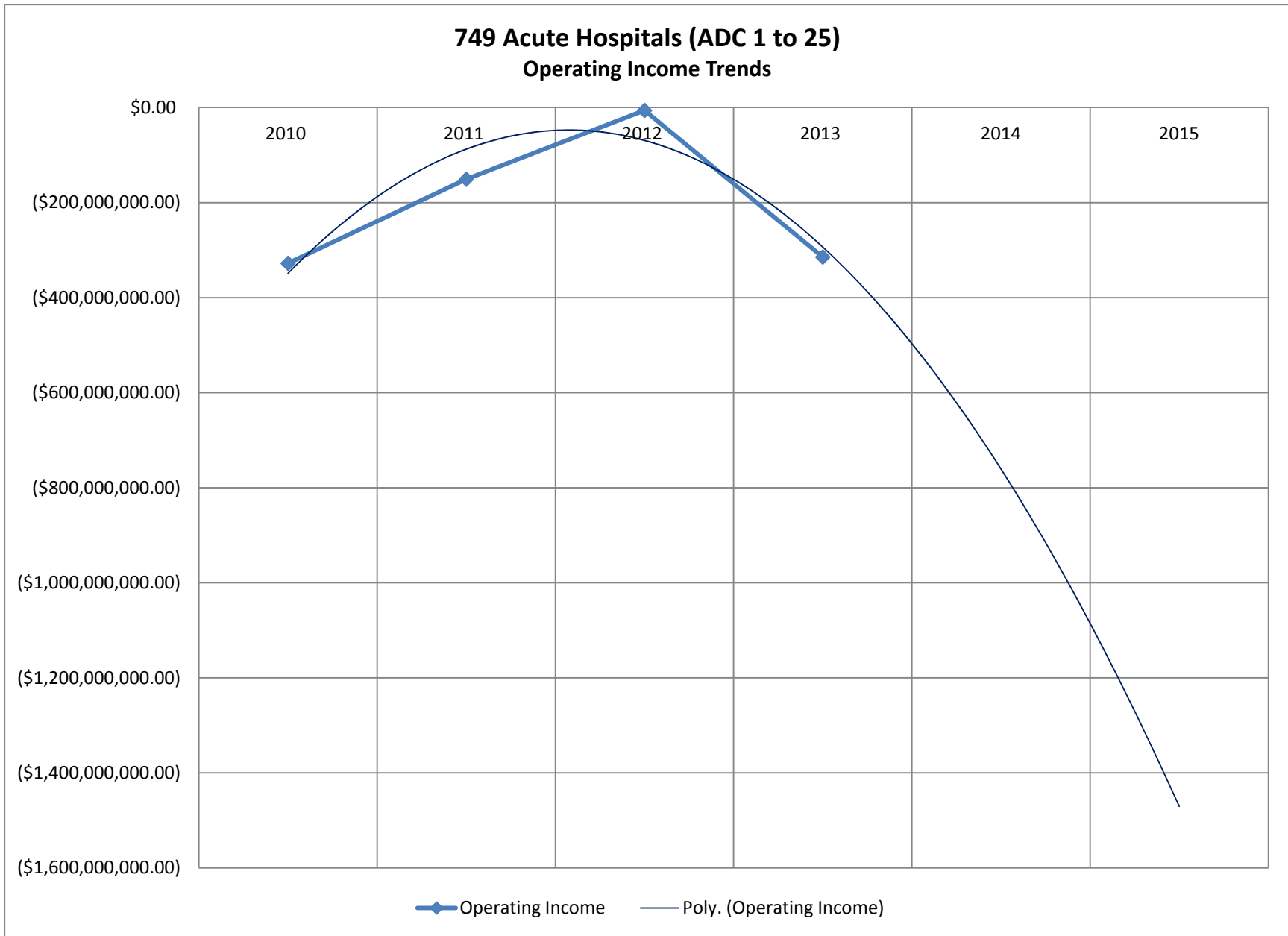


3,965 Acute Care and Critical Access Hospitals (ADC 1.02 to 1,749.55) Operating Income Trends

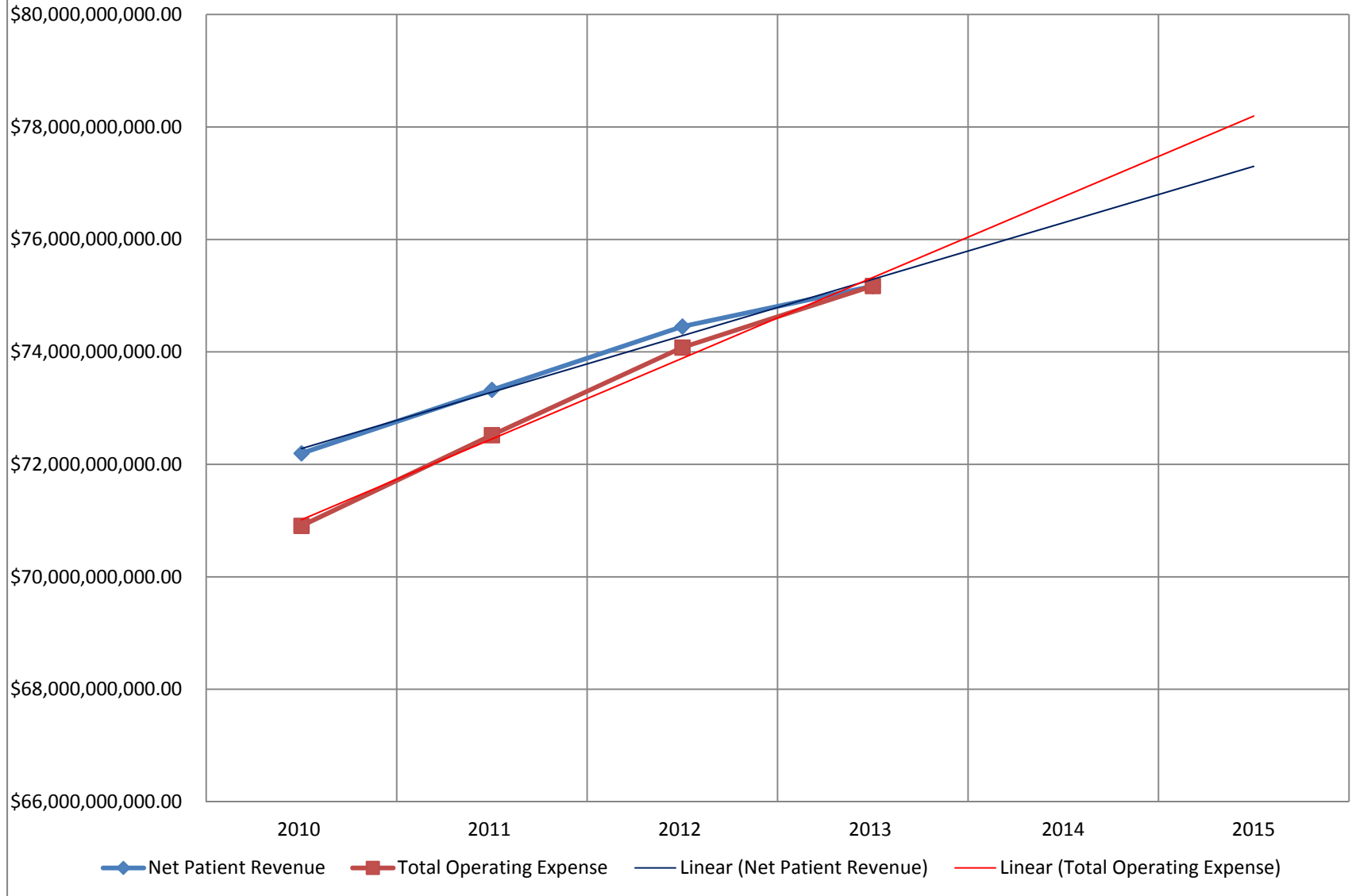


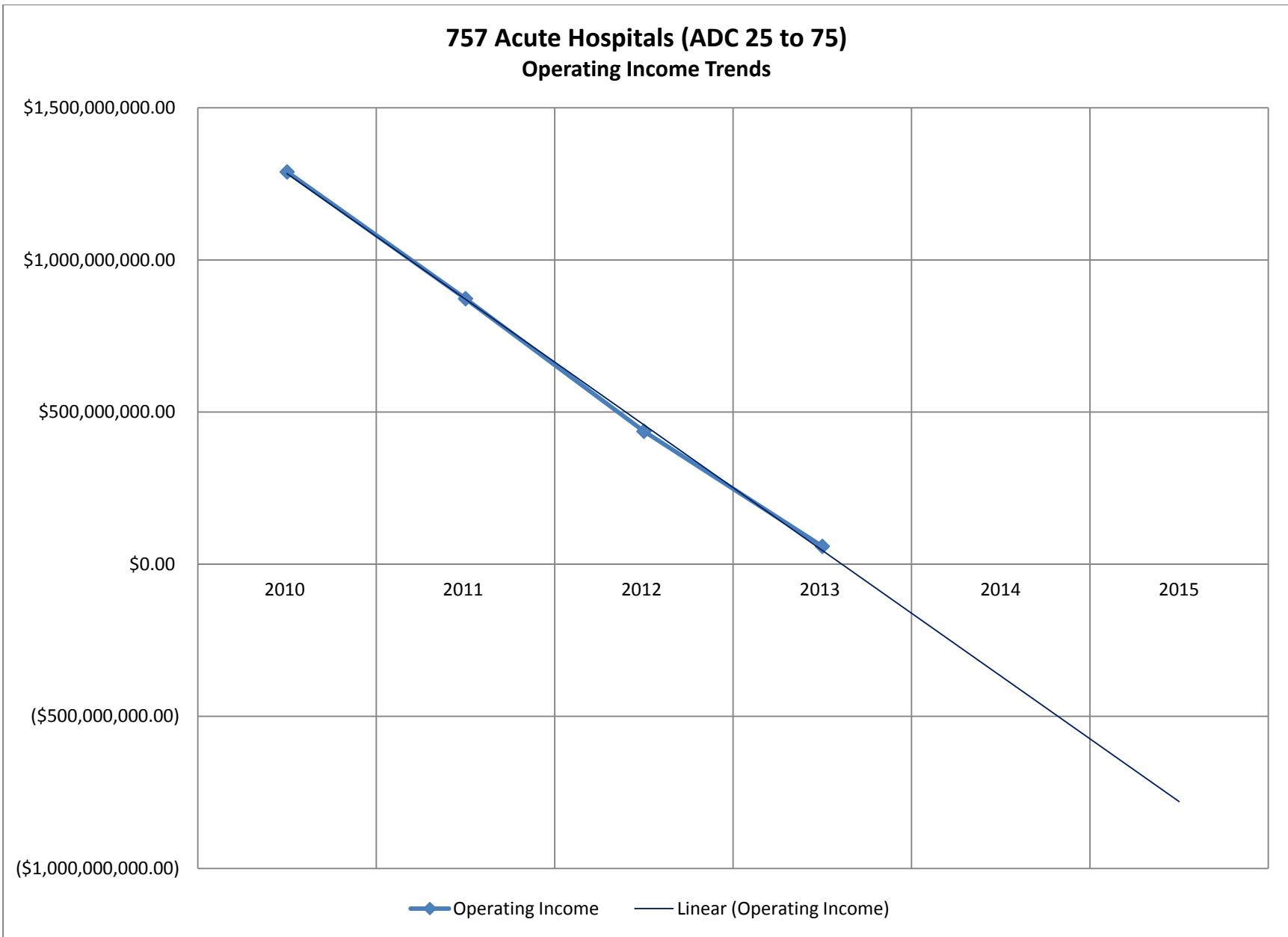
749 Acute Care Hospitals (ADC 1 to 25) Revenue and Expense Trends



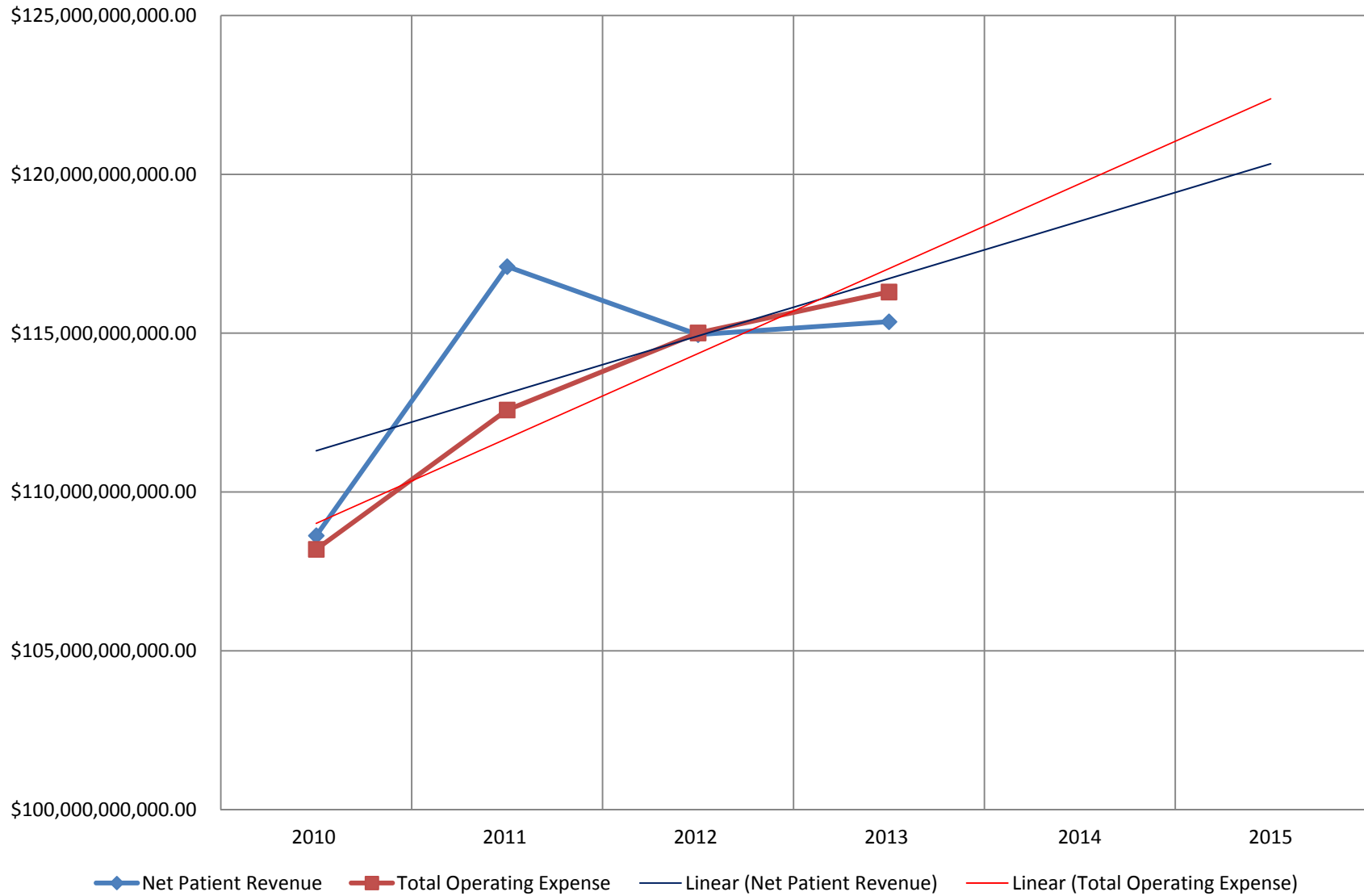


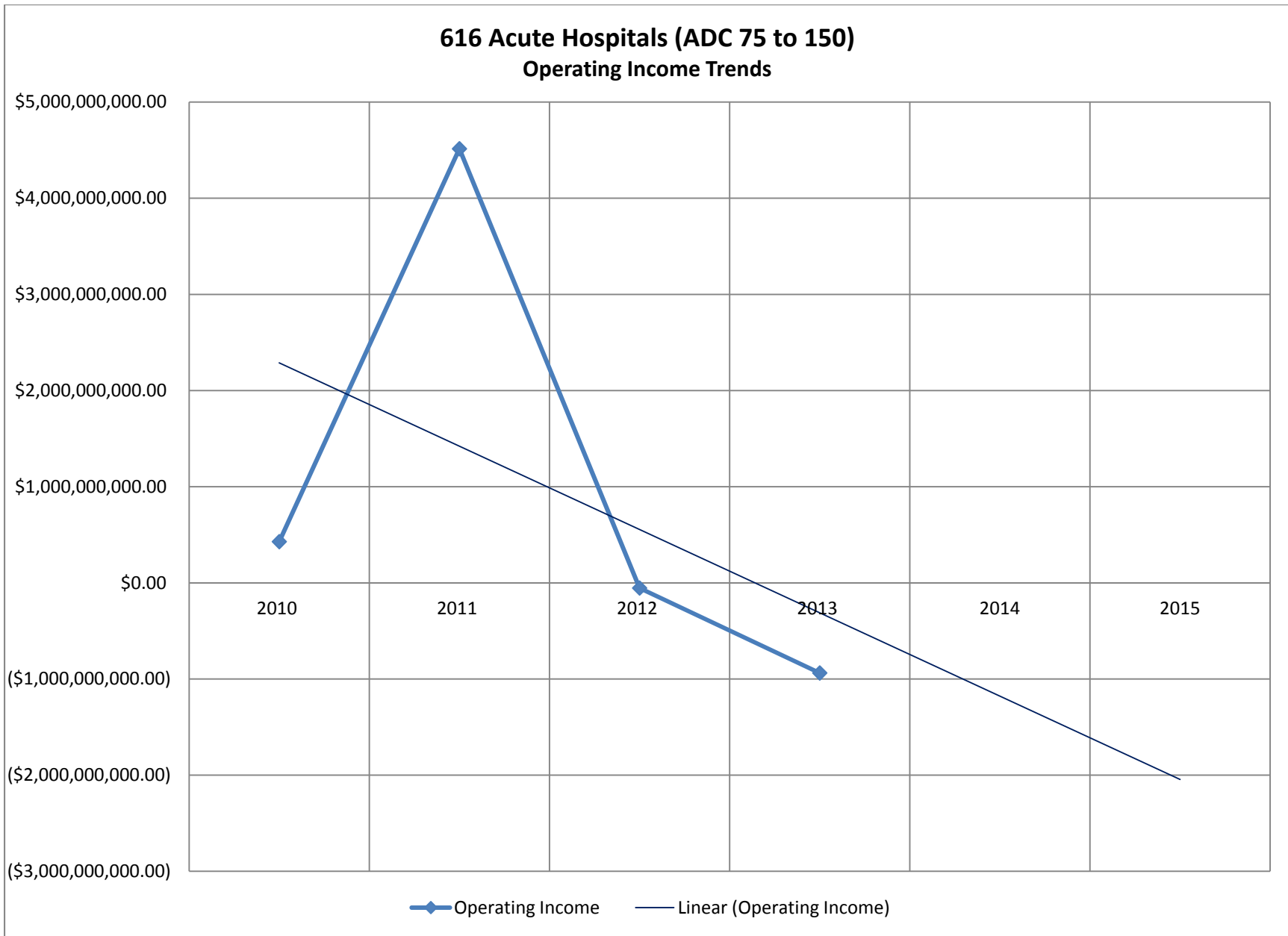
757 Acute Care Hospitals (ADC 25 to 75) Revenue and Expense Trends



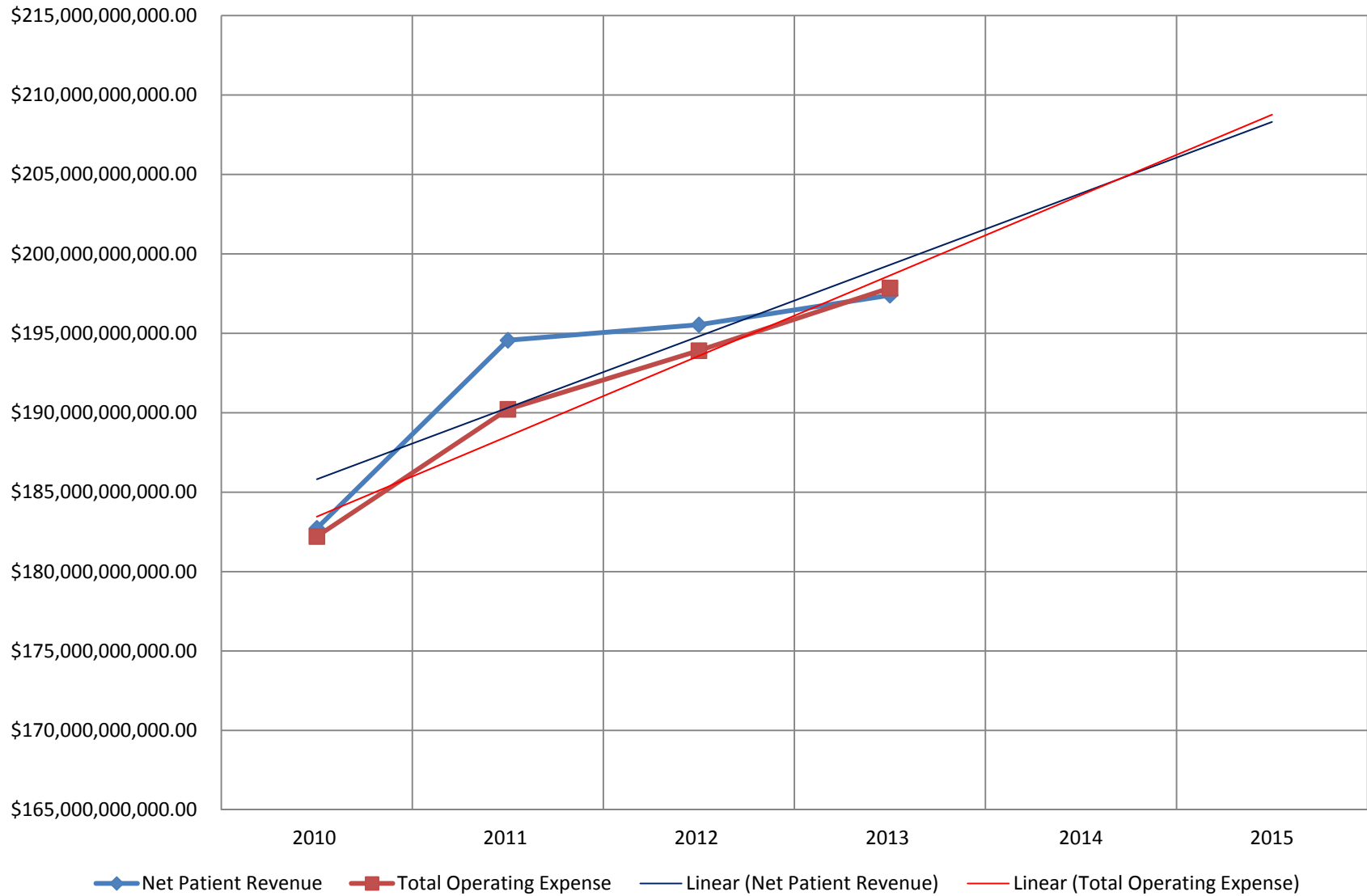


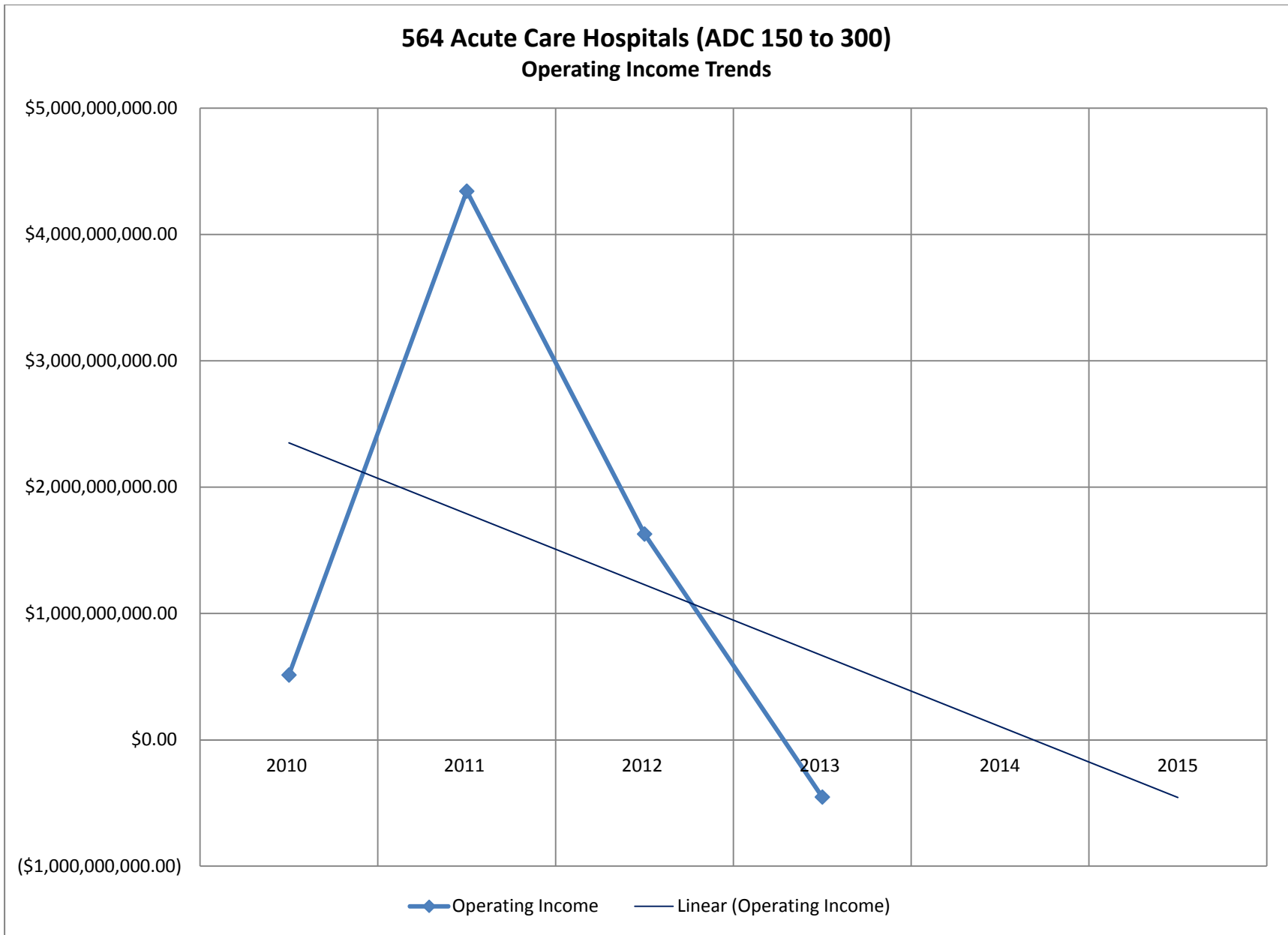
616 Acute Care Hospitals (ADC 75 to 150) Revenue and Expense Trends



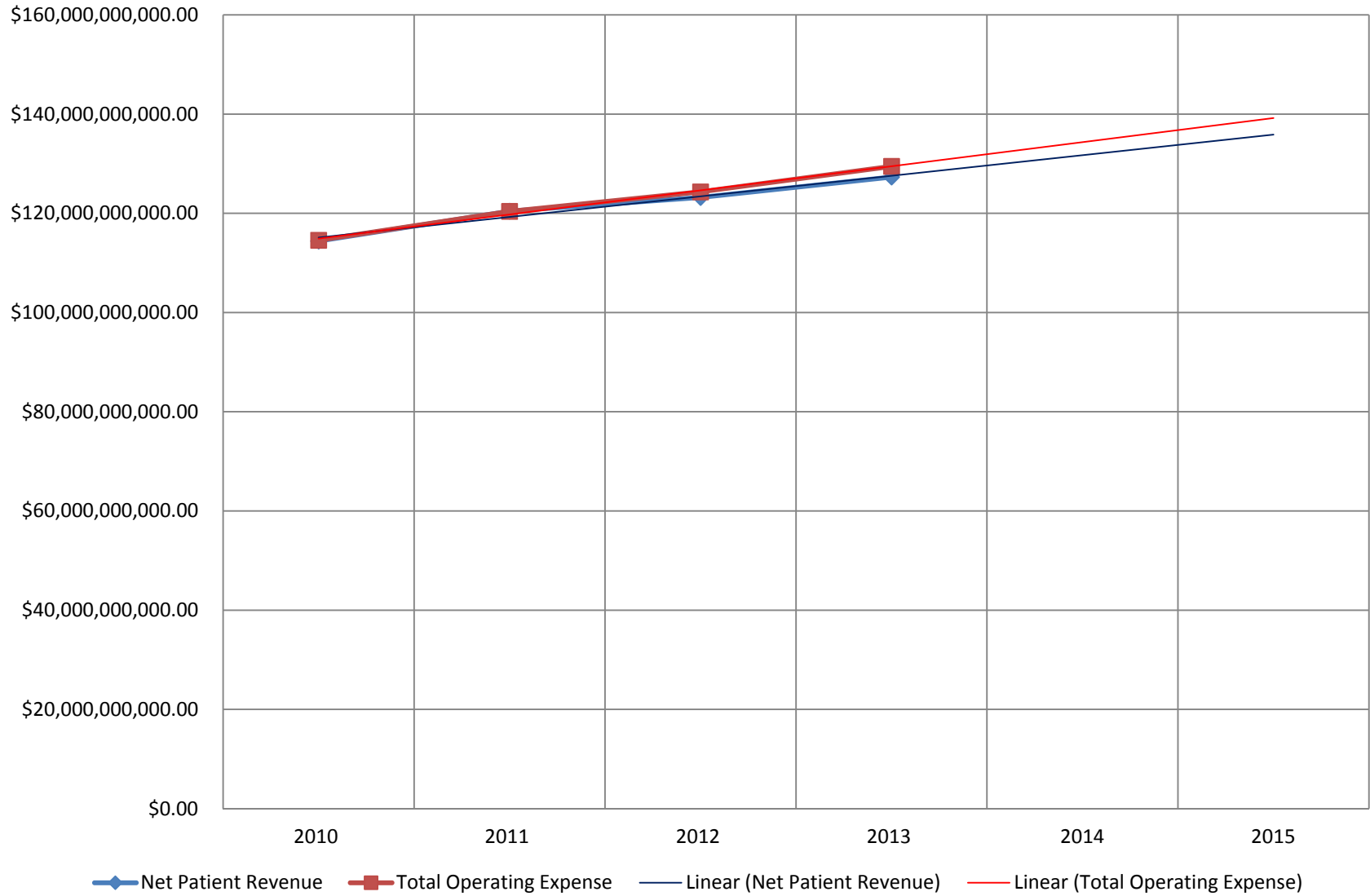


564 Acute Care Hospitals (ADC 150 to 300) Revenue and Expense Trends

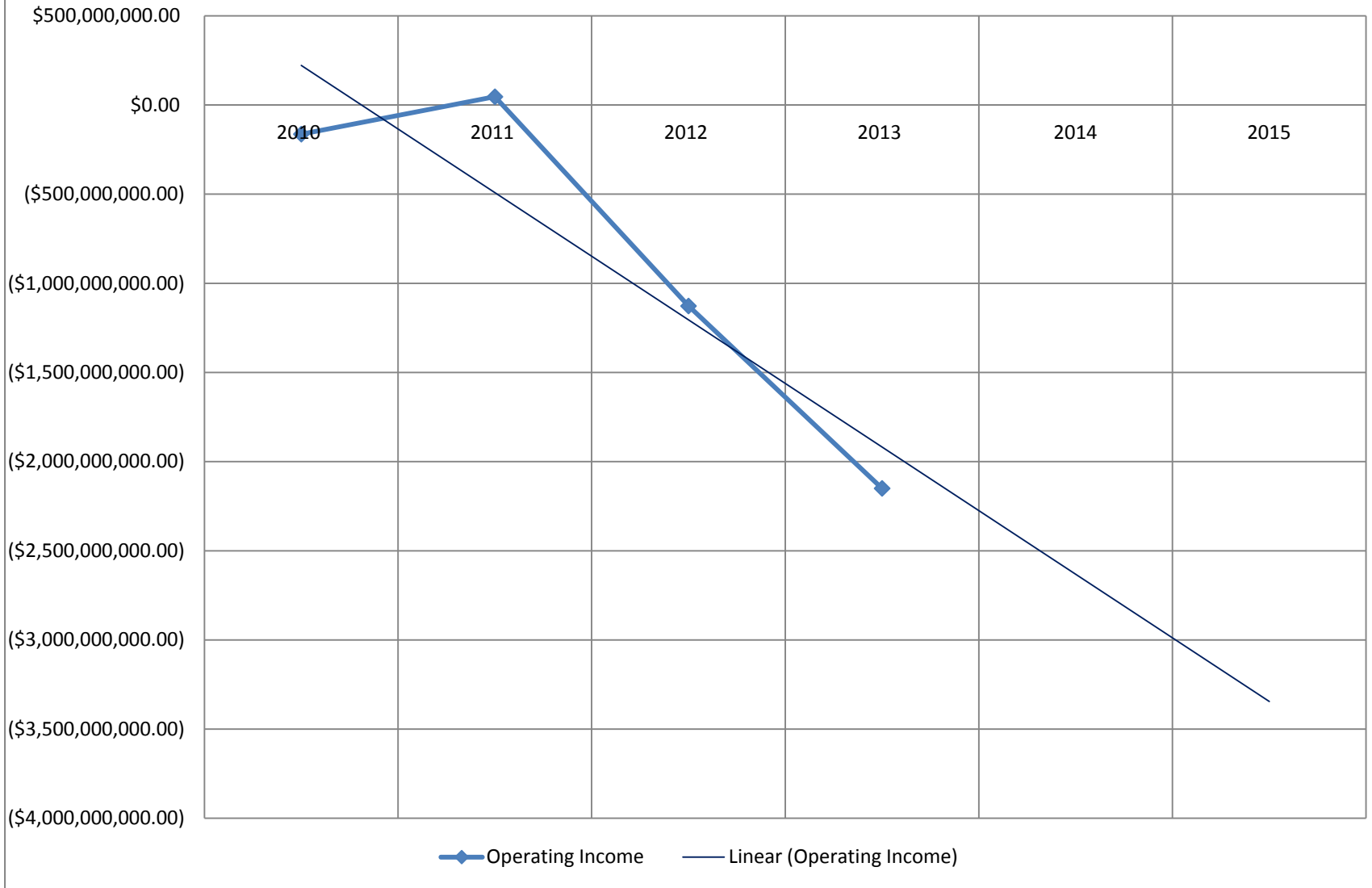




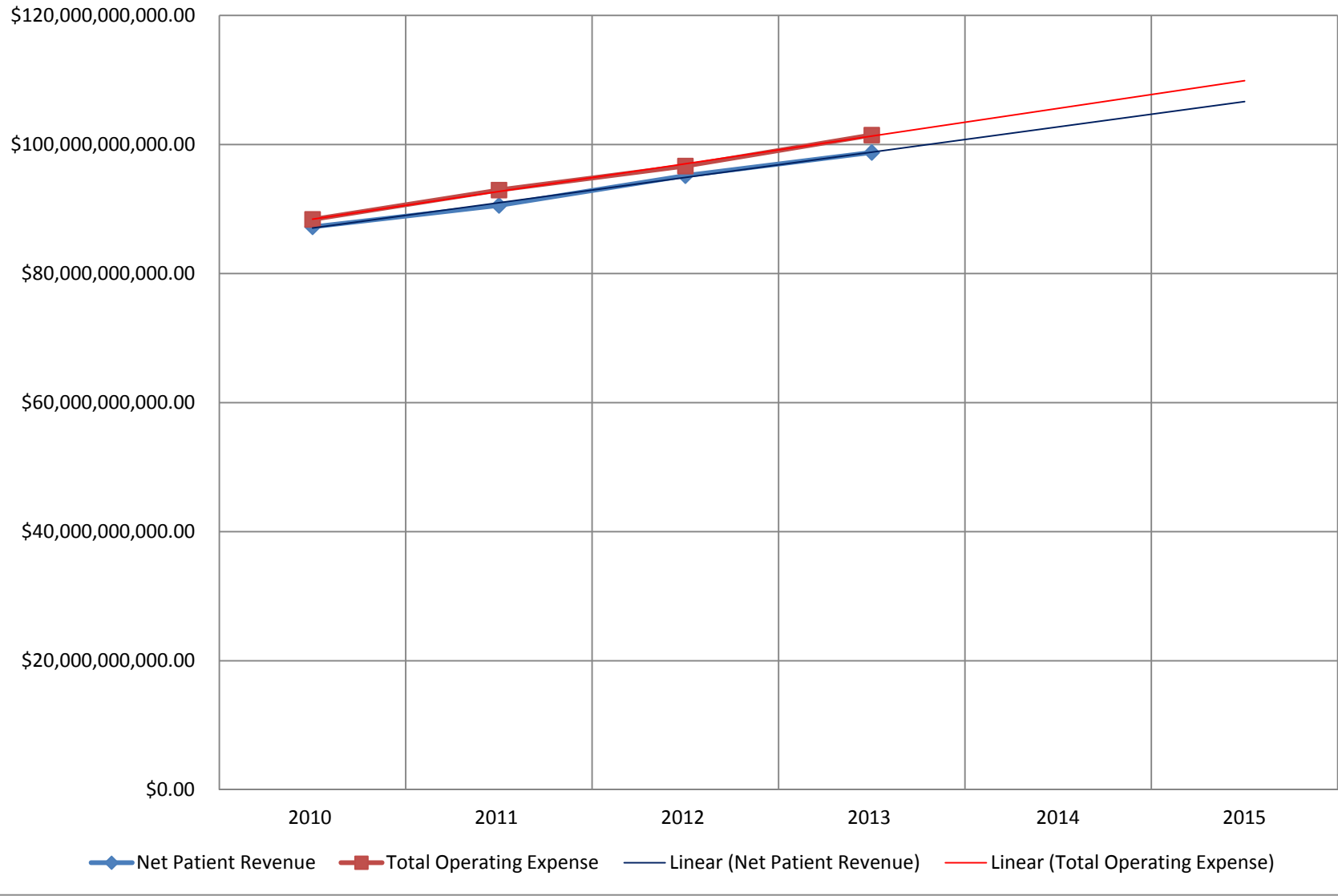
184 Acute Care Hospitals (ADC 300 to 500) Revenue and Expense Trends



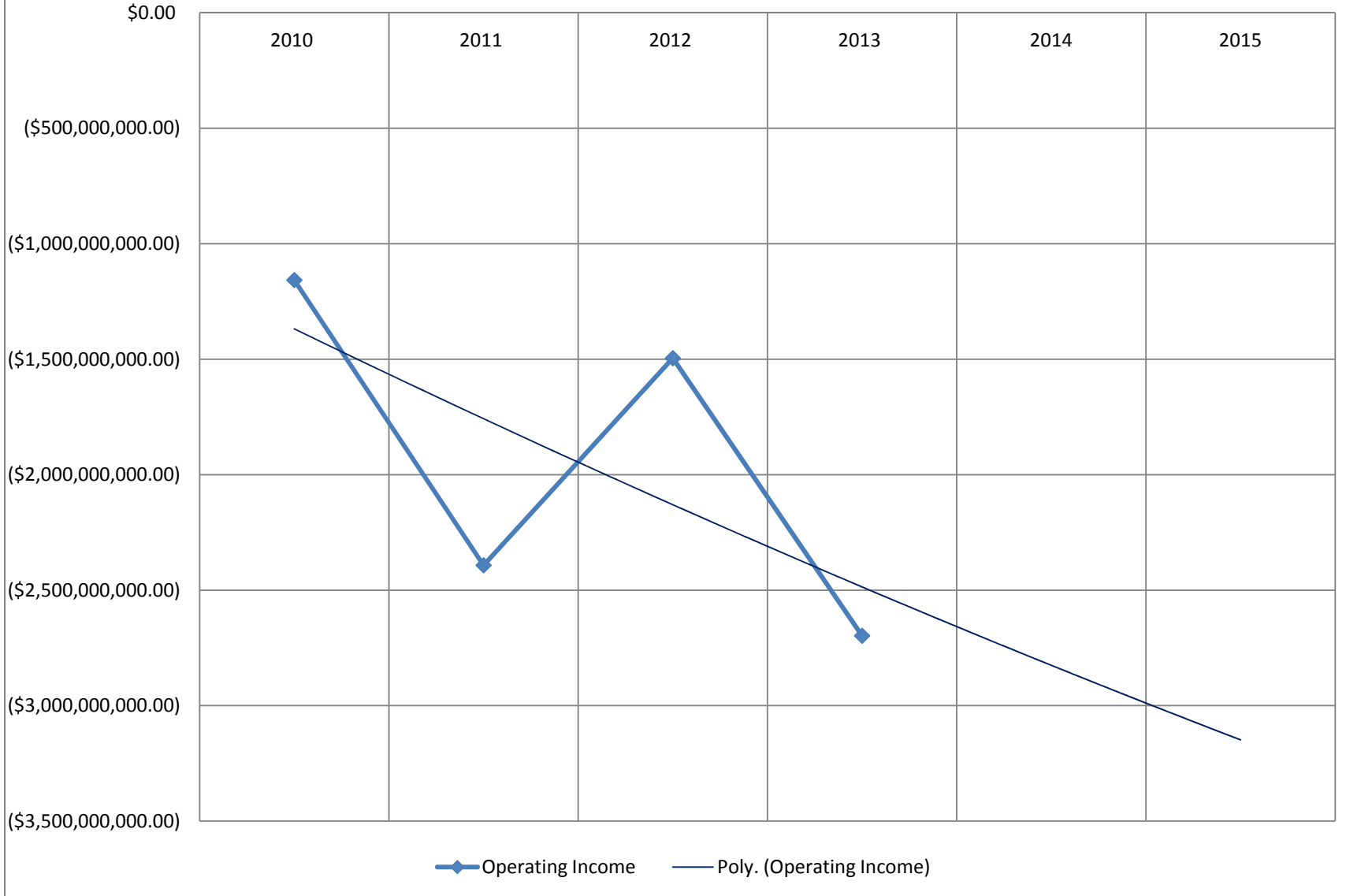
184 Acute Care Hospitals (ADC 300 to 500) Operating Income Trends



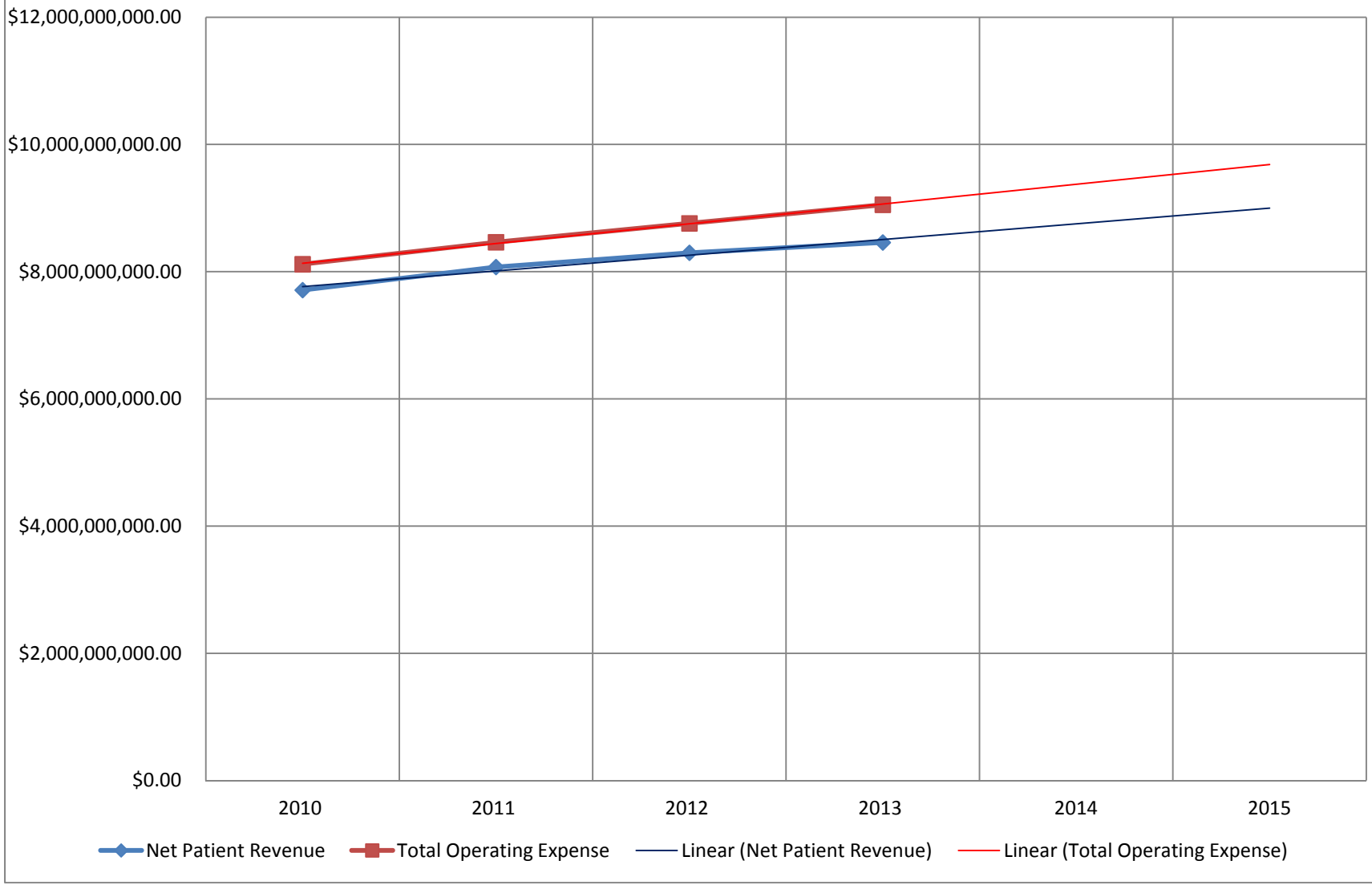
75 Acute Care Hospitals (ADC 500 and Greater) Revenue and Expense Trends



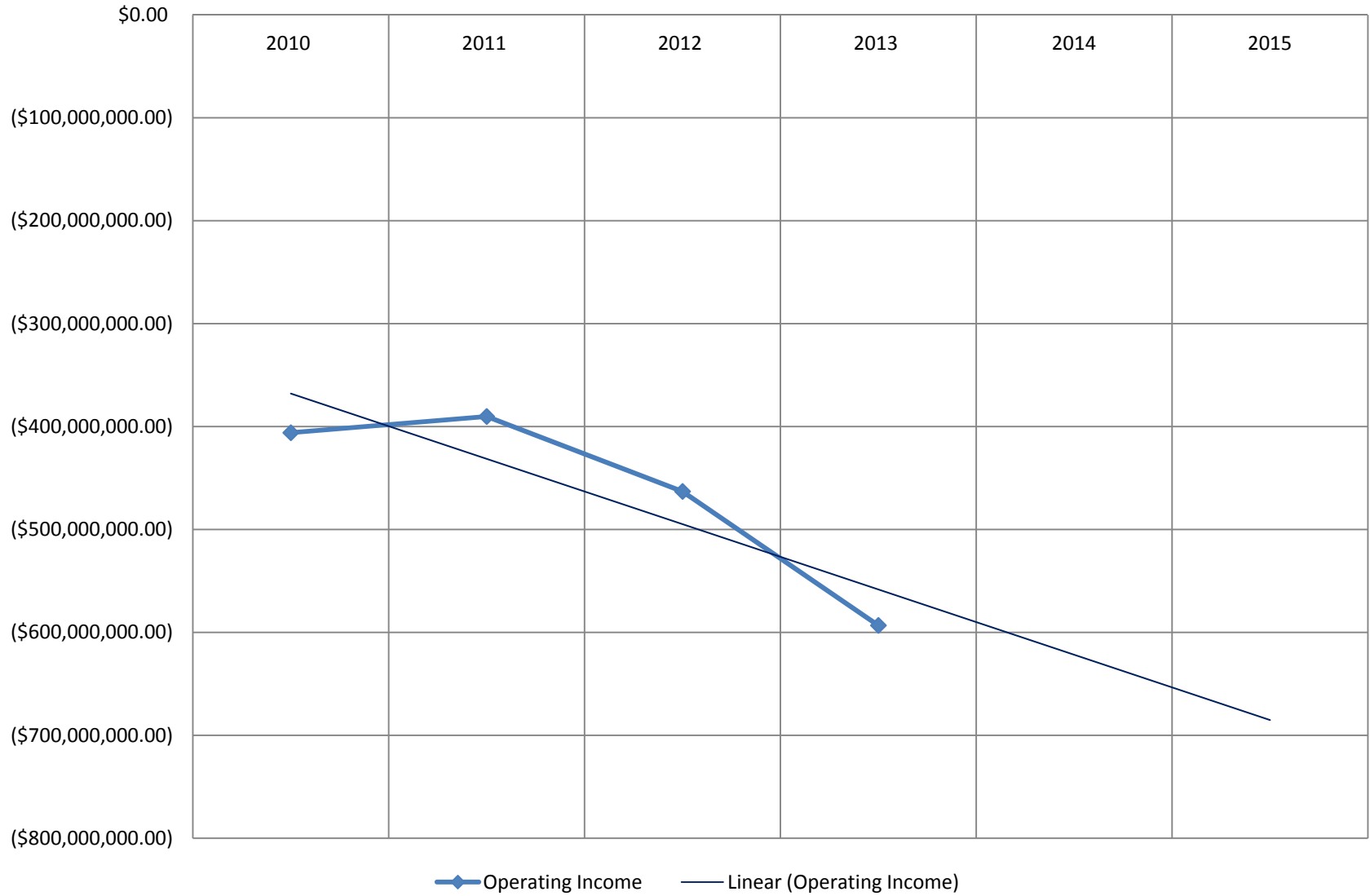
**75 Acute Care Hospitals (ADC 500 and Greater)
Operating Income Trends**



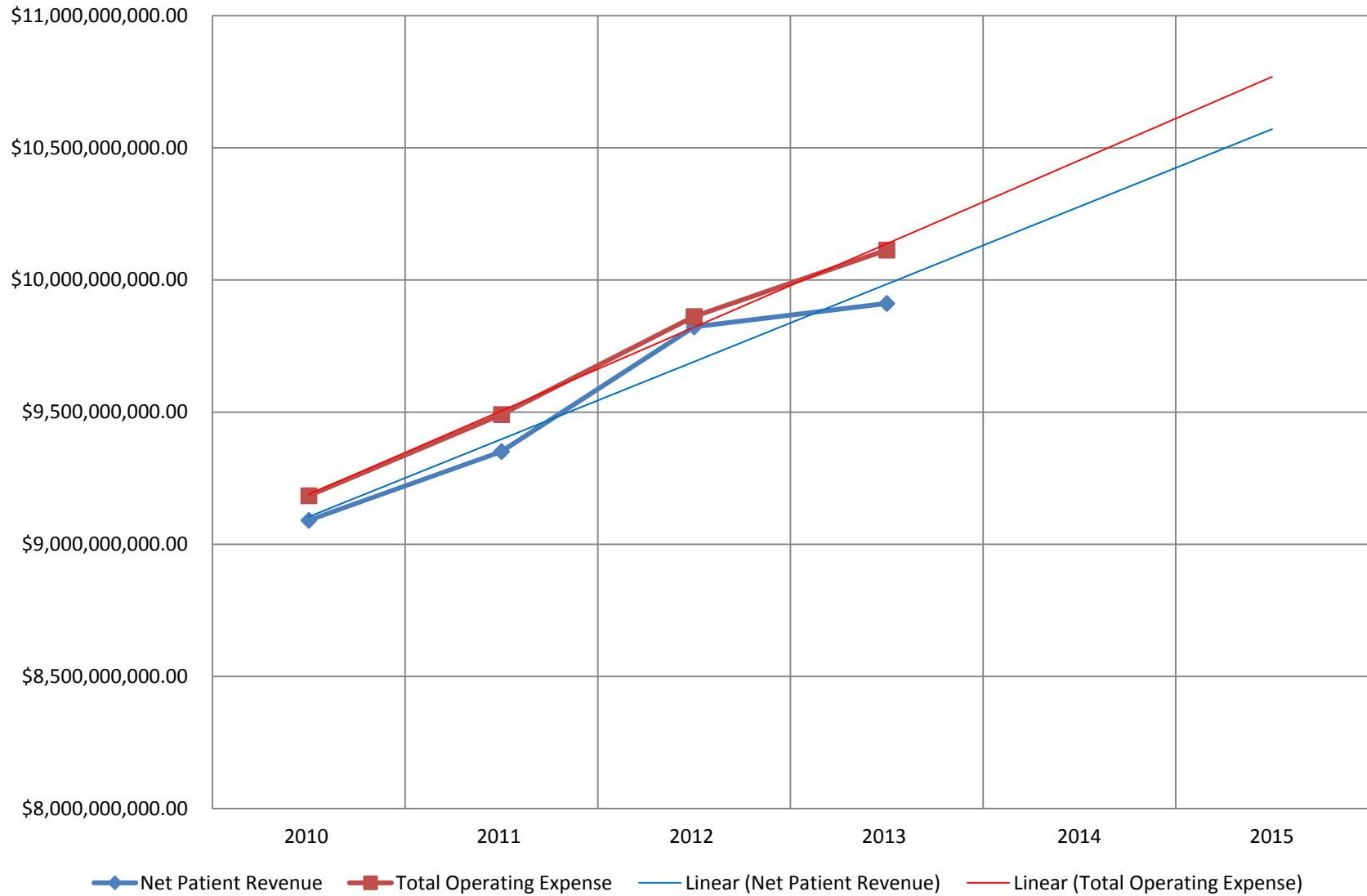
587 Critical Access Hospitals (ADC 0 to 8) Revenue and Expense Trends



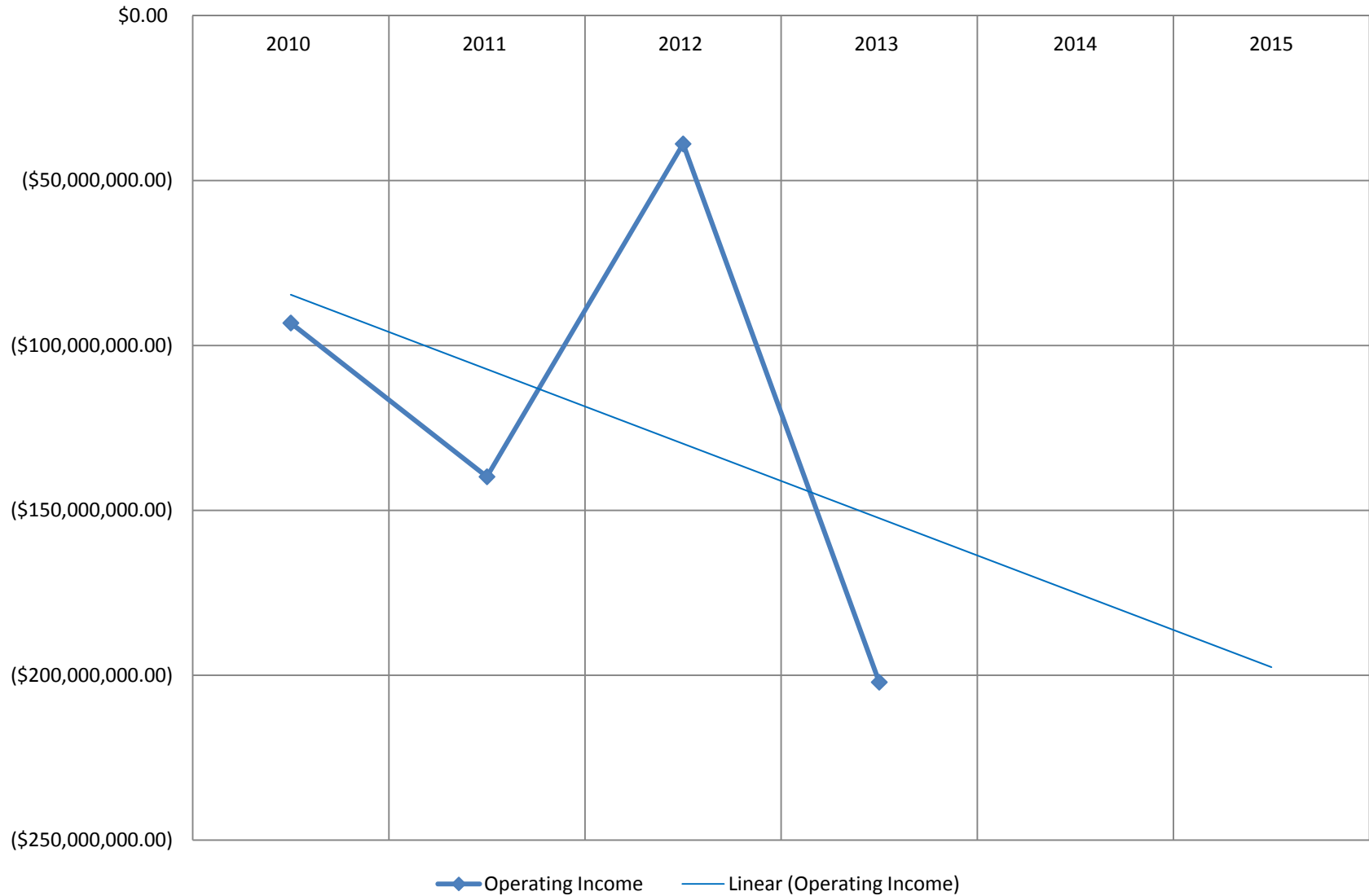
587 Critical Access Hospitals (ADC 0 to 8) Operating Income Trends



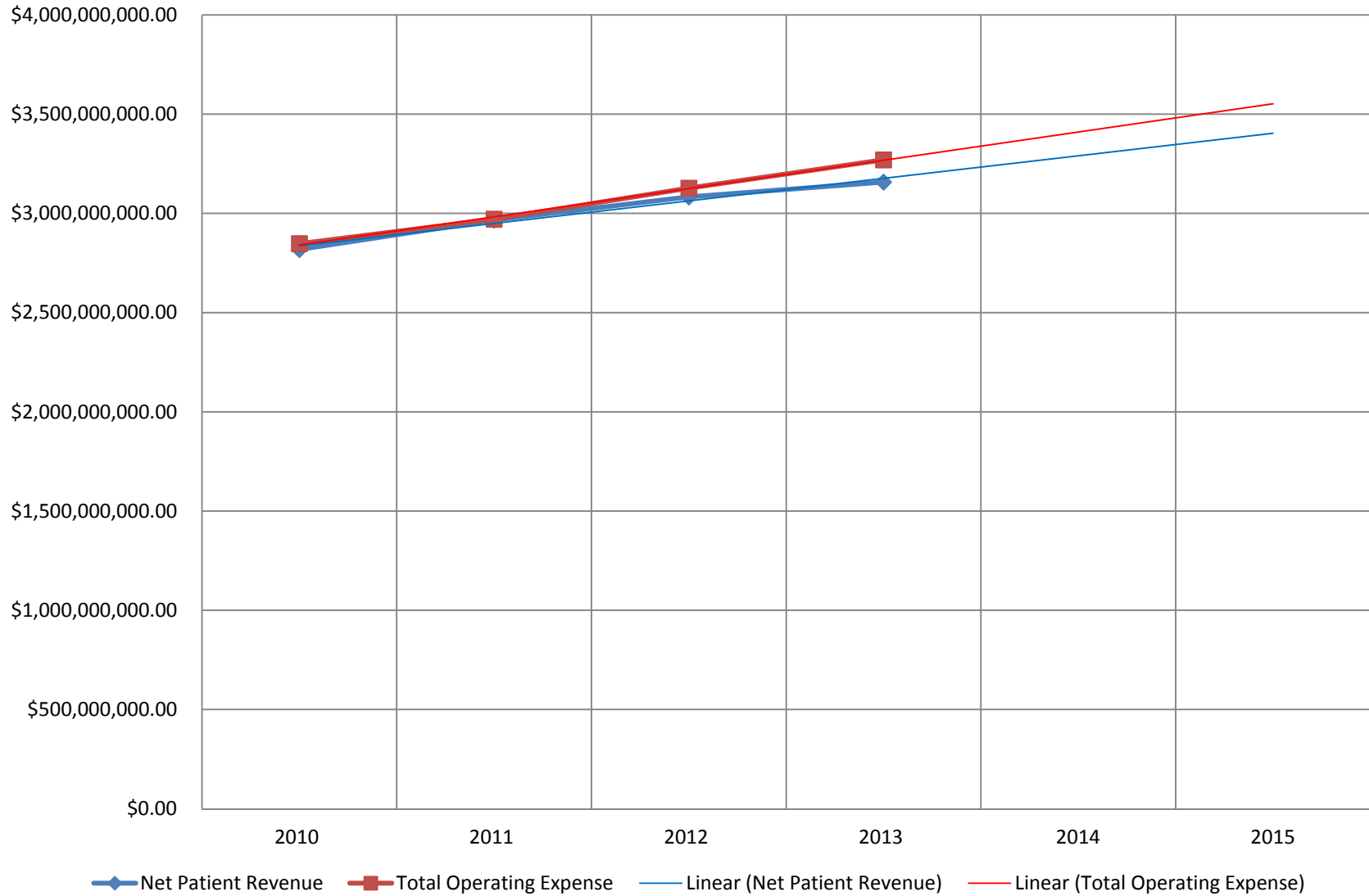
353 Critical Access Hospitals (ADC 8 to 15) Revenue and Expense Trends



353 Critical Access Hospitals (ADC 8 to 15) Operating Income Trends



80 Critical Access Hospitals (ADC 15 to 25) Revenue and Expense Trends



80 Critical Access Hospitals (ADC 15 to 25) Operating Income Trends

